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Report of the Special Committee to Investigate Israeli Practices Affecting the Human Rights of the Palestinian People and Other Arabs of the Occupied Territories

Israeli practices affecting the human rights of the Palestinian people in the Occupied Palestinian Territory, including East Jerusalem

Report by the Secretary-General**

Summary

The present report is submitted pursuant to General Assembly resolution 66/79, concerning Israeli practices affecting the human rights of the Palestinian people in the Occupied Palestinian Territory, including East Jerusalem. The report examines themes identified in resolution 66/79. In Gaza, these include the firing of rockets and mortars against Israeli civilian areas, killings and injuries in the course of hostilities and the enforcement of access-restricted areas and the blockade. In the West Bank, including East Jerusalem, the themes examined include home demolitions and forced evictions; the situation of the Bedouin communities; the continued construction of the Wall; the excessive use of force by Israeli security forces, including in the policing of demonstrations; and the arrest and detention of Palestinians by the Israeli authorities, with a particular focus on the practice of administrative detention.

* A/67/150.

** The present report is being submitted late in order to allow maximum time for Member States, United Nations system agencies, non-governmental organizations and human rights defenders to submit relevant information.

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I. Introduction

1. The present report examines progress made in the implementation of General Assembly resolution 66/79, entitled "Israeli practices affecting the human rights of the Palestinian people in the Occupied Palestinian Territory, including East Jerusalem". In the resolution, the Assembly demanded, among other things, that Israel cease all practices aimed at altering the character, status and demographic composition of the Occupied Palestinian Territory, and respect its obligations under international law, including with regard to practices and actions that violate the human rights of the Palestinian people. The period covered is from 1 July 2011 to 15 June 2012. The information contained in the report is based primarily on monitoring and other information-gathering activities carried out by the Office of the United Nations High Commissioner for Human Rights (OHCHR) and other United Nations entities in the Occupied Palestinian Territory. It also contains information obtained from Israeli, Palestinian and international non-governmental organizations (NGOs), human rights defenders and media sources.

2. In relation to Gaza, the report examines the firing of rockets and mortars against Israeli civilian areas, killings and injuries in the course of hostilities, the enforcement of access-restricted areas and the blockade of Gaza. With regard to the West Bank, the report examines Israeli practices affecting the character, status and demographic composition of the Occupied Palestinian Territory, including those leading to the displacement of Palestinians, the use of force by Israeli security forces, and arrest and detention by Israeli authorities, in particular the practice of administrative detention. The lack of protection afforded to the Palestinian people in the Occupied Palestinian Territory, including in relation to the impunity enjoyed by Israeli security forces for violations of international human rights law and international humanitarian law, is highlighted throughout the report.

3. It is noted that several themes identified in resolution 66/79 are addressed in separate reports of the Secretary-General submitted to the General Assembly at its sixty-seventh session. These themes include Israeli settlements in the Occupied Palestinian Territory, which are addressed in the report of the Secretary-General pursuant to General Assembly resolution 66/78. It is further noted that the human rights situation in the Occupied Palestinian Territory is comprehensively reviewed in the report of the United Nations High Commissioner for Human Rights on the implementation of Human Rights Council resolutions S-9/1 and S-12/1 (A/HRC/19/20).

II. Implementation of resolution 66/79

A. The situation in Gaza

1. The blockade of Gaza

4. Movement of Palestinians out of Gaza, and access within Gaza to food, basic utilities, housing, education, work, health and an adequate standard of living continued to be severely restricted. Palestinians have experienced difficulties when requesting to cross the border to seek medical treatment in the West Bank, including East Jerusalem, owing to delays of 7 to 10 days for permit applications. Between July and December 2011, 4,803 applications were filed seeking authorization to

travel to Israel by way of Erez for medical treatment. Authorization was granted to 4,457 applications and denied to 101 patients. In July 2011, one patient died while awaiting authorization.[1] OHCHR has noted a pattern of people being arrested, on alleged security grounds, after already having their permits approved.

5. The Gaza economy remained at a standstill, with Gaza's imports continuing to fall significantly short of the pre-2007 level. Apart from a limited number of United Nations projects, Israel continued barring the entry of several items that are vital for the process of reconstruction and economic recovery (e.g., construction materials, spare parts for water and sanitation projects). The unemployment rate remains one of the highest worldwide, with some 28.4 per cent of Gaza's participating workforce unemployed.[2]

6. United Nations system agencies and other international organizations have voiced concerns about the length of time required for and the costs associated with the Israeli approval process for international humanitarian projects in Gaza, which present considerable challenges for the population in the Gaza Strip and for recovery efforts in general.

7. The blockade has continued to severely restrict Gaza's exports, preventing the population in Gaza from maintaining their livelihoods and realizing their right to an adequate standard of living. As of June, Gaza exports represented only 2 per cent of the pre-2007 level.[3] On 22 January, Israeli authorities allowed the first non-agricultural exports from Gaza since the start of the blockade in June 2007. March 2012 witnessed the first transfer of goods — a pilot transfer of 140 metric tons of locally produced fortified date bars for a World Food Programme (WFP) school feeding programme in the West Bank — from the Gaza Strip to the West Bank since the start of the blockade. The transfer occurred after WFP had received the approval of the Government of Israel. Nevertheless, the crossing's limited capacity, imposed back-to-back procedure, and intense Israeli security requirements on outgoing cargo from Gaza resulted in a daily transfer limit of two truckloads.[4] Israel argues that these considerations require the continuing restrictions on exports from Gaza, preventing Gaza's products from reaching their markets in Israel and the West Bank.

2. Enforcement of access-restricted areas

8. Israel continued to impose restrictions on Palestinians accessing areas located within Gaza up to 1,500 metres from the Green Line. Palestinians entering or approaching these areas were regularly subjected to warning shots and, in some cases, were directly targeted with live ammunition. In 41 incidents during the period under review, Israeli forces fired what were reported to be warning shots at Palestinian farmers working on their land and at rubble scrap collectors. Incidents in the access-restricted area claimed the lives of two Palestinian civilians and resulted

[1] Information obtained from the World Health Organization Gaza on 5 July 2012.

[2] Palestinian Central Bureau of Statistics, Labour Force Survey, April-June 2012, Round (Q2/2012), 15 August 2012.

[3] Gisha-Legal Center for Freedom of Movement, "Graphing 5 years of closure", June 2012, available at http://www.gisha.org.

[4] Office for the Coordination of Humanitarian Affairs Occupied Palestinian Territory, *The Monthly Humanitarian Monitor*, March 2012.

in the injury of 82 civilians.[5] On 13 March, two Palestinians were injured by Israeli gunfire in an access-restricted area during a funeral. Between 28 March and 3 April 2012, the Israeli Air Force dropped pamphlets notifying the population of the 300-metre access-restricted area that they were not allowed in the area close to the fence with Israel. However, OHCHR routinely receives allegations that, in practice, the access-restricted area is vigorously enforced up to 500 metres from the fence.

9. Israeli naval forces continued to restrict the access of Palestinian fishermen to 3 nautical miles from the coast. This policy, often enforced through the use of live ammunition, severely limited access to fishing grounds. Palestinian fishermen risk arbitrary detention and confiscation of their boats by the Israeli Naval Forces. According to information gathered by local human rights organizations, a total of 66 Palestinian fishermen were detained and 18 boats were confiscated during the reporting period. In these cases, fishermen reported that they had been within the 3-nautical-mile limit and had posed no threat to Israeli naval forces. In August 2011, several boats which had been confiscated by Israel between 2010 and 2011 were returned. However, Israel had dismantled their motors, stating that they were over 25 horsepower and therefore qualified as "security equipment", and thus could not be exported to Gaza owing to their being classified as "security equipment". Israel also demanded that the owners of the boats pay fees of between NIS 3,500 and 5,000 each (approximately between $900 and $1,300) for transferring the boats from Israel.

10. In the past, the methods used to enforce the access-restricted areas imposed by Israel have not conformed to international law, have violated rules against the use of force by law enforcement officials and have resulted in significant loss of life (see A/66/356, para. 25). During the reporting period, OHCHR documented two incidents in which fishermen were shot at. These enforcement methods violate the international humanitarian law principle of distinction, which establishes that civilians are not to be targeted. Furthermore, the confiscation of fishing boats from persons that rely on fishing as their means of livelihood prevents them from exercising their right to food and to an adequate standard of living, and constitutes a violation of article 46 of the Hague Regulations, which prohibits the confiscation of private property.[6]

3. Firing of rockets and mortars against Israeli civilian areas

11. Palestinian armed groups continued firing rockets and mortar shells at Israel. A total of 752 rockets, including 642 homemade rockets and 110 Grad rockets, and 175 mortar shells were fired during the reporting period.[7] The vast majority of rockets fell short of their apparent targets and exploded in open areas in southern Israel. Many projectiles heading towards civilian populated areas were intercepted by Israel's "Iron Dome" anti-missile defence system. Rocket and mortar fire towards southern Israel resulted in the death of one Israeli civilian. In March 2012,

[5] Information made available by the Office for the Coordination of Humanitarian Affairs Sub-Office in Gaza.

[6] Regulations concerning the Laws and Customs of War on Land (Hague Regulations), annex to the 1907 Hague Convention respecting the Laws and Customs of War on Land.

[7] Data made available by the United Nations Department of Safety and Security to OHCHR on 17 June 2012.

11 Israeli civilians were injured by such rocket fire.[4] One Palestinian child was also killed, and six others injured, by a rocket fired by Palestinian armed groups.

12. The poor accuracy of these rockets means that their use is inherently indiscriminate, and therefore contrary to international humanitarian laws prohibiting indiscriminate attacks, the use of inherently indiscriminate weapons, and acts aimed at spreading terror among the civilian population. Further, it has been alleged that such rockets and mortars are often fired from densely populated areas, which would violate customary international humanitarian law.

4. Killings and injuries in the course of hostilities

13. Israeli-Palestinian conflict-related violence claimed the lives of 90 Palestinians in Gaza, including 31 civilians, of whom 8 were children. Hostilities during the reporting period resulted in the injury of 371 Palestinians in Gaza, including 299 civilians, of whom 85 were children. The most intense escalations related to armed conflict occurred in August 2011 and March 2012. In August 2011, hostilities resulted in the death of 29 Palestinians, including 9 civilians, and 101 injured, including 89 civilians. In March 2012, hostilities in Gaza and southern Israel again claimed the lives of 25 Palestinians, including 5 civilians, and resulted in the injury of 116 Palestinians, 103 of them civilians.[4] Most Israeli air strikes appeared to target rocket-launching crews, military training bases and tunnels under the Gaza-Egypt border. However, civilian infrastructure was affected. In August, Israeli air strikes damaged several homes and public facilities, including a United Nations Relief and Works Agency (UNRWA) school, a not-yet-operational sewage pumping station and a university campus.

14. These cases raise questions regarding the respect on the part of the Israeli Defense Forces (IDF) for the basic provisions of international law when planning and carrying out attacks. These provisions include the obligation of combating parties to take the necessary precautions to minimize harm to civilians and civil objects, and to distinguish between civilians and combatants and between civilian objects and military targets. The principle of proportionality forbids an attack that may be expected to cause incidental loss to civilian life, injury to civilians, damage to civilian objects, or a combination thereof, which would be excessive in relation to the concrete and direct military advantage anticipated. The principle of necessity allows the use of violence insofar as it is appropriate to accomplish the military objective. The killing of civilians not taking part in hostilities may also violate the right to life as guaranteed by article 6 of the International Covenant on Civil and Political Rights.

B. The situation in the West Bank including East Jerusalem

1. Excessive use of force by Israeli security forces

(a) Killings and injuries during operations of Israeli security forces

15. Excessive use of force by Israeli security forces, including IDF and the Israeli Border Police, in their policing operations in the West Bank continued to be a cause of concern during the reporting period. Nine Palestinian civilians, including 2 children, were killed, while 2,453 Palestinian civilians were injured, including 318 children, by Israeli security forces operating in the West Bank. The total number

of injuries increased by 35 per cent compared with that in the same reporting period in 2011.[8] While most injuries occurred during demonstrations, civilians were also injured and killed as a result of the excessive use of force during other forms of military operations. The following case was monitored by OHCHR.

16. On 27 March 2012, three brothers in Rammun noticed two unknown men on the neighbour's car. Thinking that they might be thieves, the brothers went out to check, and asked the two men to identify themselves. The men responded in Arabic but did not identify themselves. A confrontation ensued, and the two unidentified men opened fire at the three brothers. One brother was shot in the leg, another was shot in the neck, and the third was shot in the abdomen. Several dozen uniformed IDF soldiers suddenly appeared. Two of the brothers were shot by uniformed soldiers, with one being struck seven times at close range. The soldiers checked the two men — who, it later turned out, were undercover IDF soldiers — for injuries, and they departed forthwith.[9] Palestinian ambulances were prohibited by IDF soldiers from providing medical assistance to the wounded. After approximately 40 minutes, the wounded were put in IDF jeeps and transported to Taybeh junction. Crews from two Palestinian ambulances requested to be allowed to assist the wounded, but the IDF soldiers again refused. Israeli ambulances eventually took the wounded to a hospital in Jerusalem. The man who had been shot seven times at close range died of his injuries. An autopsy report obtained by OHCHR confirmed that the victim had died as a result of "live fire shot from close range".[10] The two other brothers were released from the hospital several days after the incident.

17. In the West Bank, Israeli forces act in a law-enforcement capacity and are therefore bound by article 6 of the International Covenant on Civil and Political Rights and article 43 of the Hague Regulations, in addition to general principles on the use of force by law enforcement officials, including the principles of necessity and proportionality contained in the Basic Principles on the Use of Force and Firearms by Law Enforcement Officials, 1990,[11] and the Code of Conduct for Law Enforcement Officials, 1979 (see General Assembly resolution 34/169, annex). Independent, prompt and effective investigations into such incidents are critical to ensure accountability for deaths and injuries. Should negligent or unlawful behaviour be identified during such investigations, judicial and/or disciplinary proceedings should be initiated against those responsible. The investigation should also seek to determine whether the soldiers involved acted in conformity with the relevant internal regulations concerning, as applicable, crowd-control methods and open-fire regulations, as well as whether these regulations are consistent with international standards.

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[8] Information received from the Office for the Coordination of Humanitarian Affairs.

[9] On 18 April, Israeli media reported that the unit involved in the incident was the "Duvdevan" unit (known for their undercover operations) and that they were on a training mission when two undercover soldiers were attacked by three men. See http://www.ynetnews.com/articles/0,7340,L-4217835,00.html.

[10] Autopsy report for Rashad Deeb Hassan Shoukha dated 24 June 2012, issued by the Palestinian National Authority, Ministry of Justice, Palestinian Medico Legal Center.

[11] Adopted by the Eighth United Nations Congress on the Prevention of Crime and the Treatment of Offenders, Havana, Cuba, 27 August to 7 September 1990.

(b) Excessive use of force in the policing of demonstrations and the right to freedom of expression

18. During the reporting period, Palestinian communities across the West Bank organized protests in response to the Israeli authorities' confiscation of privately owned Palestinian land for the construction of settlements, the expansion of already existing settlements, the construction of the Wall, home demolitions, and the eviction of Palestinians from their homes or continuous violence by settlers against Palestinians and their property. Protests took place on a regular basis in about 16 different locations across the West Bank, including Nabi Saleh, Bil'in, Ni'lin, al-Ma'sara, 'Assira, Kufr Ed-Deek, Kafr Qaddum, Qaryout, Beit Ummar, al-Walaja, Hebron (Shuhada Street), Cremisan (Beit Jala), Nahalin, 'Araba, Silwan and Sheikh Jarrah. The following concerns were identified during such demonstrations and need to be addressed.

Freedom of expression and freedom of assembly denied

19. Military Order 101 "Regarding the Prohibition of Acts of Incitement and Hostile Propaganda" (the Order), issued by the Commander of IDF in the West Bank region on 27 August 1967, regulates the right of Palestinians to demonstrate in the West Bank. The Order is excessively restrictive and prevents Palestinians from exercising their right to freedom of expression. The Order describes "assembly", "rally" and "procession" as follows. An "assembly" is "ten or more persons gathering for the purpose of a speech or discussion on a political topic or a topic that may be interpreted as political". A "rally" is "ten or more persons gathering for a political purpose or for a matter that could be interpreted as political". A "procession" is "a group of ten or more persons advancing or intending to advance from a place to place, for a political purpose or for a matter that could be interpreted as political, whether or not they are actually moving or have organized themselves as a group" (sect. 1: Definitions). While the Order outlaws "assemblies, processions and rallies" that take place without a permit issued by a military commander, it does not enunciate in any way how this permit should be sought or the conditions for such a permit to be issued (sect. 3A). The Order prevents Palestinians from flying flags or distributing political material and outlaws "incitement" by "any person who orally or in any other way attempts to influence public opinion in the region in a way that is liable to disturb public peace or order, or carries out any action or possesses any object with the intention of executing or facilitating the execution of such an attempt" (sect. 7). The framework established by the Order imposes undue restrictions on the right of Palestinians to freedoms of assembly, opinion and expression. In practice, a Palestinian family of 10 persons or more sitting in their home and discussing politics would be considered an illegal assembly pursuant to the Order.[12] As pointed out by the Special Rapporteur on the promotion and protection of the right to freedom of opinion and expression, Military Order 101 represents a "sweeping prohibition of expression deemed to be 'political' which is vague and subject to interpretation" (see A/HRC/20/17, para. 78).

[12] See also B'Tselem, "The right to demonstrate in the occupied territories", July 2010, available at http://www.btselem.org/download/20100715_right_to_demonstrate_eng.pdf.

Unnecessary and disproportionate use of force against unarmed protesters

20. Israeli security forces respond to peaceful assemblies through the use of various crowd control means. As explained above, Israeli security forces in the West Bank act in a law-enforcement capacity and are bound by a number of international standards, including the Code of Conduct for Law Enforcement Officials and the Basic Principles on the Use of Force and Firearms by Law Enforcement Officials. These documents reflect standards that are internationally agreed upon, which national authorities need to integrate into their applicable procedures and training programmes. OHCHR has documented numerous incidents where the use of force by Israeli security forces during protests raised a number of concerns.

21. Injuries and the use of unnecessary and disproportionate force are documented on a weekly basis by United Nations entities and by Palestinian, Israeli and international human rights organizations. For example, in the village of Nabi Saleh, injuries, arrests and other practices, including night raids on private homes, often accompanied by damages to and confiscation of private property, occur on a weekly basis. In the first five months of 2012, a total of 1,204 Palestinians were injured by Israeli security forces during demonstrations that took place in the West Bank, 584 of them in May alone, including 12 women and 37 children.[13]

Targeting of journalists and media personnel

22. Journalists should be allowed to report on protests in safety and free from intimidation and violence. OHCHR documented four cases during the first half of 2012, where journalists or photographers appear to have been directly targeted by IDF or the Border Police, including with rubber-coated metal bullets, despite being clearly visible as members of the press by wearing "PRESS" vests and carrying cameras or other equipment. The targeting by Israeli security forces of journalists and photographers covering protests in the West Bank, including East Jerusalem, is a cause of concern.

The death of Mustafa Tamimi

23. On 9 December 2011, during clashes between Palestinians and Israeli security forces in Nabi Saleh, an Israeli soldier in the back of an armoured vehicle fired tear gas, at a distance of less than 5 metres, directly at a Palestinian man, Mustafa Tamimi, who had been throwing stones at the vehicle. The tear gas canister hit the victim below his right eye. He immediately fell to the ground and was eventually taken to a hospital in Petah Tiqwa. On the following morning, Mr. Tamimi was pronounced dead, owing to injuries sustained from this incident. Photos of the incident were obtained by OHCHR.

24. Statements by IDF following the incident indicated that two separate investigations had been initiated by Israeli authorities, one of which was to be concluded by 20 December 2011. In a letter dated 19 January 2012 to the Permanent Mission of Israel to the United Nations in Geneva, OHCHR requested information on the status and outcome of the two investigations and on the bodies involved in the investigations. OHCHR also requested information on the rules of engagement and other applicable regulations on the use of crowd-control weaponry, including

[13] Office for the Coordination of Humanitarian Affairs Occupied Palestinian Territory, *The Monthly Humanitarian Monitor*, May 2012, p. 3.

firing tear gas and the use of rubber-coated metal bullets. To date, no response has been received from the Israeli authorities.

2. Arrest and detention in particular the phenomenon of administrative detention

(a) Palestinian prisoners in Israeli detention

25. The hunger strikes of two Palestinian detainees, Khader Adnan and Hanan Shalabi, to protest administrative detention were followed, beginning on 17 April 2012, by an organized mass hunger strike of approximately 1,700 Palestinians in Israeli detention. The detainees demanded, among other things, an end to solitary confinement, the practice of administrative detention by Israel, the resumption of family visits for detainees from Gaza and better conditions and treatment. On 14 May, the Israeli authorities reportedly agreed to end solitary confinement, to allow prisoners from Gaza to receive family visits and to discuss an improvement of detention conditions, as well as the conditional non-extension of administrative detention orders against certain Palestinians. The full and effective implementation of the deal is critical. The vast majority of Palestinians in Israeli detention are held in prisons and detention centres located outside the occupied territory, in clear violation of international humanitarian law, which provides that residents of an occupied territory are to be detained within the occupied territory.[14]

(b) The practice of administrative detention

26. Administrative detention has been practised in the Occupied Palestinian Territory by the Israeli authorities since the beginning of the occupation in 1967. Currently, over 300 Palestinians are being held under the regime of administrative detention, the majority of them under Military Order 1591. While administrative detention is not prohibited per se under international law, a number of principles govern its use: it should only be used in an exceptional manner and only for imperative reasons of security; it should never be used as an alternative to criminal proceedings; if a person is suspected of a criminal offence, he or she should be charged and be tried by a regularly constituted court that is independent, impartial and respects all judicial guarantees; administrative detention must be based on procedures established by law and should be subject to review by an independent and impartial body; the detainee must be allowed to receive effective legal assistance; and the detainee and his or her counsel should be present at the review of the lawfulness of the detention.

27. The Israeli practice of administrative detention falls short of these standards. One of the most problematic issues is that in most cases, evidence on which the detention order is based is kept secret and neither the detainee nor his or her counsel has access to it. These restrictions on access to the evidence are not limited to reviews by military courts, but also apply when decisions are appealed at the level of the High Court of Justice. However, according to human rights organizations, including B'Tselem, in most cases, the only information communicated to the detainee or his counsel for the reason of the detention is that the detainee is a member or activist of an armed group, without any further details.[15] Not allowing the detainee or his or her counsel access to "secret evidence" does not allow them to

[14] Art. 76 of the Fourth Geneva Convention of 1949.

[15] See http://www.btselem.org/administrative_detention/criticism_on_the_administrative_detention_order.

contest the reasons on which the detention order is based and therefore renders any review ineffective. According to the Working Group on Arbitrary Detention, military courts and military appeals court do not, generally, offer an effective means to challenge administrative detention orders, as they are not independent and impartial. Such courts consist of military personnel, who are subject to military discipline and are dependent on superiors within the military bureaucracy for promotion.[16]

(c) Palestinian children in Israeli detention

28. As at the end of May 2012, 234 Palestinian boys between the ages of 12 and 17 were in Israeli detention for alleged security violations, marking a 73 per cent increase since December 2011. Nineteen children from the West Bank were reportedly transferred to prisons inside Israel, in contravention of article 76 of the Geneva Convention relative to the Protection of Civilian Persons in Time of War, of 12 August 1949.[17]

29. In relation to the cases of detention mentioned above, a sample of 40 cases was documented through affidavits, including 17 that occurred in January and February 2012. All of the 40 Palestinian boys aged 13 to 16, who provided sworn affidavits, reported being subjected to ill-treatment by Israeli security forces. Sixty-seven per cent of the children suffered at least 10 different types of ill-treatment, including, but not limited to, being hand-tied excessively tightly, blindfolded, strip-searched, leg-tied, verbally abused, denied access to water and food and denied access to toilets, not informed of their rights, and not allowed the presence of a parent or lawyer.[18]

30. These practices violate Israel's obligations under the Convention on the Rights of the Child and provisions of international humanitarian law. Article 37 (b) of the Convention provides that "the arrest or imprisonment of a child shall be used only as a measure of last resort and for the shortest appropriate period of time". Article 76 of the Fourth Geneva Convention highlights that "proper regard shall be paid to the special treatment due to minors".

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[16] Conclusion of the Working Group on Arbitrary Detention, Opinion No. 5/2010 (Israel), para. 31 (see A/HRC/16/47/Add.1)

[17] Information received from the United Nations Children's Fund (UNICEF).

[18] Ibid. See also Office for the Coordination of Humanitarian Affairs Occupied Palestinian Territory, *The Humanitarian Monitor*, May 2012, pp. 7 and 8.

3. Israeli practices affecting the character, status and demographic composition of the Occupied Palestinian Territory, including those leading to the displacement of Palestinians

(a) Evictions and home demolitions in Area C and East Jerusalem[19]

31. Forced evictions are prima facie incompatible with international human rights law, in particular the right to adequate housing and freedom from arbitrary or unlawful interference with privacy, family and home, pursuant to article 11 of the International Covenant on Economic, Social and Cultural Rights and article 17 of the International Covenant on Civil and Political Rights. They are only justified in the most exceptional circumstances, must pursue a legitimate purpose and must be implemented in accordance with international law, including the prohibition of discrimination.

32. Between July 2011 and July 2012, the forced displacement of Palestinians continued, particularly among the already vulnerable Bedouin and herding communities in Area C. In comparison with 2010, displacement has almost doubled. Between July 2011 and June 2012, almost 909 Palestinians, 447 of them children, were forcibly displaced as a result of home demolitions by Israeli forces in the West Bank, including East Jerusalem. In total, Israeli forces destroyed almost 560 Palestinian-owned structures during the reporting period, of which 184 were residences. Most of the remaining structures were animal shelters (117), rainwater cisterns or pools (44) and mosques (2). Humanitarian assistance organizations have also had their materials confiscated on several occasions.[8]

33. In East Jerusalem, demolitions resumed in the last quarter of 2011, ending a de facto "freeze" since 2010. During the reporting period, 55 structures were demolished in East Jerusalem.[20] On 18 April 2012, the families of Khalid An Natshe and Suleiman An Natshe were forcibly evicted from their homes in the neighbourhood of Beit Hanina after an Israeli Jerusalem district court had ruled in favour of an Israeli citizen claiming ownership of part of the plot of land where the house is located. This resulted in a total of 13 Palestine refugees, 9 of whom are children, being rendered homeless. Another two Palestinian refugee families living in Beit Hanina, totalling 21 persons, faced imminent eviction at the end of the reporting period, as Israeli courts moved to execute a 1968 confiscation order.[21]

34. A growing concern is the increase in the number of obstacles for Palestinians wanting to use legal measures to prevent evictions and demolitions. Such obstacles may constitute violations of the right to an effective remedy pursuant to article 2 of

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[19] Under the 1993 Oslo Accords between Israel and the Palestine Liberation Organization, the West Bank was temporarily divided into three administrative zones referred to as Areas A, B and C. Area A includes the major Palestinian cities, and is under Palestinian civil and security authority. Area B comprises most Palestinian rural communities, and civil authority is under the Palestinian Authority, while security responsibilities are shared by both the Israeli and Palestinian authorities. Areas A and B make up roughly 38 percent of the West Bank. Approximately 62 per cent of the area of the West Bank is in Area C, where Israel retains authority over law enforcement and control over the building and planning sphere. The Oslo Accords called for the gradual transfer of power and responsibility in the sphere of planning and zoning in Area C from Israel to the Palestinian Authority (PA).

[20] Information received from the Office for the Coordination of Humanitarian Affairs. See also the report of the Secretary-General on Israeli settlements.

[21] Cases documented by UNRWA.

the International Covenant on Civil and Political Rights. Available information indicates that in 2012, the Israeli Civil Administration (ICA)[22] has dramatically decreased the time limits within which Palestinians can appeal "stop work" and demolition orders against their residential and livelihoods structures in Area C — from 14 days in the past to just a few days. If the hearing is not attended, the demolition can now be executed within three days. Recently, following the rejection of the appeal, demolitions have been executed within less than 24 hours. These dramatically reduced time frames effectively prevent Palestinians from lodging an appeal against demolition orders.

35. The Israeli authorities maintain that demolitions are carried out against structures which were built without the required building permits. However, in reality it is essentially impossible for Palestinians to obtain such permits.[23] The Security Council has not accepted claims by Israel that such cases in East Jerusalem are a matter for municipal authorities and domestic courts. By its resolution 478 (1980), the Council determined that "all legislative and administrative measures and actions taken by Israel, the occupying Power, which have altered or purport to alter the character and status of the Holy City of Jerusalem ... are null and void and must be rescinded forthwith" (resolution 478 (1980)).

(b) The situation of Bedouin communities

36. In July 2011, ICA indicated its intention to "relocate" approximately 27,000 Bedouin and herding Palestinians living in Area C throughout the Jerusalem periphery, Jordan Valley and South Hebron Hills.[24] It was reported that the ICA plan involved the relocation of about 20 communities in the municipal area of the Maale Adummim settlement (encompassing some 2,300 Palestinians, 80 per cent of whom are Palestinian refugees), reportedly to a location where there were grave environmental and health safety concerns.[25] Between July 2011 and 15 June 2012, all 20 communities in the eastern periphery had experienced increasing pressure on their livelihoods, including repeated demolitions, settler violence, access restrictions and the disruption of basic services.[26] As at 15 June 2012, the planned relocation awaited the results of an environmental study mandated by the Israeli parliament.

37. The proposed transfer by Israel of Bedouins and other communities residing in the West Bank within the Jerusalem periphery raises serious concerns. Its implementation would amount to individual and mass forcible transfers and forced evictions contrary to Israel's obligations under international humanitarian and human rights laws. In the context of occupation, individual or mass forcible

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[22] ICA is a body of IDF in charge of coordinating Government activities in the occupied territories.

[23] This is examined in detail in the 2011 report of the Secretary-General on Israeli settlements (A/66/364). See also Office for the Coordination of Humanitarian Affairs documents, at http://www.ochaopt.org/documents/ocha_opt_jerusalem_report_2011_03_23_web_english.pdf and http://www.ochaopt.org/documents/ocha_opt_planning_crisis_east_jerusalem_april_2009_english.pdf.

[24] B'Tselem, "Israel plans to expel Bedouin communities from Area C, West Bank", report issued on 10 October 2011; and Israeli Committee Against House Demolitions, "Nowhere left to go — Arab al-Jahalin Bedouin ethnic displacement", report issued in October 2011.

[25] B'Tselem, see footnote 24 above.

[26] Information received from UNRWA. See also Office for the Coordination of Humanitarian Affairs Occupied Palestinian Territory, Fact-sheet: "Bedouin relocation: threat of displacement in the Jerusalem periphery", 1 September 2011.

transfers of protected persons are prohibited, except for temporary transfers for the security of the population or for imperative military reasons in the context of hostilities.[27] Neither of these are the case with the Bedouin communities. Even if the affected individuals express consent, the transfer would be forcible, unless there is genuine and fully informed consent of the affected persons. Consent would not be genuine in an environment marked by the use or threat of physical force, coercion, fear of violence or duress. Furthermore, the proposed transfer may entail the destruction of private property, which would raise serious concerns about the violation of the prohibitions on destruction of private property under international humanitarian law, pursuant to article 53 of the Fourth Geneva Convention and article 46 of the Hague Regulations of 1907, as well as violate article 17 of the Universal Declaration of Human Rights.[28]

(c) Issues of concern in East Jerusalem

Revocation of residency rights, including the situation of members of the Palestinian Legislative Council

38. Israel regulates the Palestinian residents of East Jerusalem as if they were other foreign nationals living in Israel, with no regard for their circumstances as protected persons under international humanitarian law. As such, Palestinian residents lose their permanent residency status if they reside outside Israel or East Jerusalem for a period of seven years, or if they obtain permanent residency or citizenship in another country, as stipulated in the Entry into Israel Regulations (regulation 11(a)). Human rights organizations reported that 101 Palestinians had their residency revoked in 2011, including 51 women and 20 minors.[29]

39. The situation of the four elected members of the Palestinian Legislative Council (PLC), Mohamed Abu-Teir, Ahmad Attoun, Mohamed Totah and Khaled Abu Arafeh, continues to be of concern. Following their election to the Council in 2006, their residency status was revoked by the Israeli Minister of Interior on grounds of their "lack of loyalty to the State of Israel", owing to their membership in the parliament of a "hostile entity". Mr. Abu-Teir was forcibly transferred from East Jerusalem to another part of the West Bank by Israeli security forces, and was subsequently rearrested by the Israeli authorities in September 2011. He is currently held in administrative detention. Following the initial rearrest of Mr. Abu-Teir, the three other PLC members sought refuge at the premises of the International Committee of the Red Cross (ICRC) in East Jerusalem. Mr. Attoun was arrested on the premises of ICRC in September 2011 and was forcibly transferred to another part of the West Bank on 7 December 2011. He remains at this location without any identification, which places him at risk of arrest and severely hinders his freedom of movement. Mr. Totah and Mr. Abu Arafeh were subsequently arrested by Israeli Special Forces from inside ICRC premises on 23 January 2012. Both were charged with illegal presence in Israel and are currently held by the Israeli authorities. The residency case of the four PLC members is yet to be decided by the Israeli High

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[27] Art. 49 of the Fourth Geneva Convention.

[28] Art. 17 of the Universal Declaration of Human Rights: (1) Everyone has the right to own property alone as well as in association with others. (2) No one shall be arbitrarily deprived of his property.

[29] See "Israel admits it revoked residency rights of a quarter million Palestinians since 1967", *Haaretz*, 12 June 2012.

Court. The case has been pending since 2006, impinging upon the rights of the four PLC members, notably to family life, movement and liberty.

40. The requirement of "loyalty to the State of Israel" is not only a violation of international humanitarian law, which prohibits the imposition of "allegiance to the hostile power",[30] but also violates other international human rights law obligations, including the right to freedom of opinion and expression and the prohibition of discrimination on political grounds.[31]

Closure of Palestinian non-governmental organizations in East Jerusalem

41. On 25 October 2011, four registered Palestinian NGOs[32] operating in Jerusalem were handed "closure orders" by the Israeli police for a period of one month, based on the Prevention of Terrorism Law of 1948. The orders were subsequently extended for a year and the offices of the NGOs sealed. While these orders can be appealed within two weeks, evidence is not revealed to persons filing the appeal, thereby preventing any meaningful appeal. According to human rights organizations, since 2001 the Israeli authorities have closed down at least 28 Palestinian organizations operating in Jerusalem that had been involved in educational, cultural and social activities for Palestinians in East Jerusalem, including the Orient House, the Jerusalem Chamber of Commerce, the Cultural Forum Society, the Higher Tourist Culture Center, the Small Project Center and the Arab Studies Society.

(d) Access, movement and continued construction of the Wall

42. In April 2012, the Israeli authorities implemented measures easing Palestinian movement to and from the four main cities in the West Bank (excluding East Jerusalem): Nablus, Tulkarm, Salfit and Ramallah. At the same time, there were some 540 obstacles obstructing Palestinian movement within the West Bank (excluding East Jerusalem). These included 59 permanently staffed checkpoints (excluding checkpoints on the Green Line), 26 partial checkpoints (staffed on an ad hoc basis) and about 455 unstaffed physical obstacles, including roadblocks, earth mounds, earthen walls, road gates, road barriers and trenches. This system of restrictions continues to hinder Palestinian access to basic services, including health, education and sources of water. Overall, 200,000 people from 70 villages are forced to detour between two and five times longer than the direct route to their closest city.[88] Such restrictions may constitute violations under article 12 of the International Covenant on Civil and Political Rights.[33]

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[30] Art. 45 of the Hague Regulations. Art. 49 of the Fourth Geneva Convention also prohibits the forcible transfer of protected persons, except when necessary to ensure the security of the civilians involved.

[31] For further information, see B'Tselem, at http://www.btselem.org/jerusalem/20100718_revocation_of_residency_of_hamas_mps; and Carter Center, at http://www.cartercenter.org/news/pr/palestine-072210.html.

[32] Shuaa Women's Association, Al-Quds Development Foundation, Work Without Borders and Saeed Educational Center.

[33] See para. 14 of International Covenant on Civil and Political Rights General Comment No. 27 (Freedom of movement): "Restrictive measures must conform to the principle of proportionality; they must be appropriate to achieve their protective function; they must be the least intrusive instrument amongst those which might achieve the desired result; and they must be proportionate to the interest to be protected."

43. The Wall, in conjunction with its gate and permit regime, continues to be the single largest obstacle to Palestinian movement within the West Bank. Approximately 61.8 per cent of the 708-kilometre-long Wall is complete, more than twice the length of the 320-kilometre-long 1949 Armistice Line (Green Line) between the West Bank, not including East Jerusalem, and Israel. A further 8.2 per cent is under construction, and 30 per cent is planned but not yet constructed. When completed, the majority of the route, approximately 85 per cent, will run inside the West Bank, including East Jerusalem, rather than along the Green Line.

44. In its advisory opinion *Legal Consequences of the Construction of a Wall in the Occupied Palestinian Territory* of 9 July 2004, issued at the request of the General Assembly, the International Court of Justice concluded that Israel is obligated to cease construction of the Wall inside the Occupied Palestinian Territory, to dismantle the existing portions inside the Occupied Palestinian Territory and to make reparations for damages caused by the construction of the Wall.[34] Israel has yet to comply with the advisory opinion.

The Jordan Valley and Dead Sea area

45. The Jordan Valley and Dead Sea area covers around 30 per cent of the West Bank and is home to nearly 60,000 Palestinians. Eighty-seven per cent of the land is designated as Area C, virtually all of which is prohibited for Palestinian use, earmarked instead for the use of the Israeli military or Israeli settlers. An additional 7 per cent is formally part of Area B but is unavailable for development, as it was designated a nature reserve under the 1998 Wye River agreement. Palestinian access to and from the area is limited to six routes, four of which are controlled by Israeli checkpoints, severely restricting the movement of Palestinians. The restrictions on access to transportation routes, agricultural land and water resources hamper the Palestinian agricultural sector. The denial of access to the Dead Sea has also prevented the development of a potential source of revenue and employment. Meanwhile, Israeli settlers have developed profitable agricultural, mineral, touristic and other businesses.

The situation in An Nabi Samuel

46. The village of An Nabi Samuel, located 4 kilometres north of Jerusalem, is another example of a Palestinian community affected by the Wall. The village currently has a population of 290 persons. It witnessed waves of displacement, particularly during the 1967 war, the demolition of 46 houses by Israeli authorities in 1971 and the imposition of a permit regime that severely restricts construction in Area C. While the village is located outside the Israeli-defined boundaries of East Jerusalem, the construction of the Wall around Giva'at Ze'ev settlement in 2005 placed it on the "Jerusalem" side of the Wall. The village has become physically separated from its surroundings, and Palestinians' access between their homes and basic services in the rest of the West Bank has become regulated through a checkpoint. The majority of the village's population has West Bank identification documents, meaning that they cannot travel to East Jerusalem without obtaining permits from the Israeli authorities.[35] In addition to the restrictive zoning and

[34] Advisory opinion, paras. 142 and 150-153.

[35] Although there is no checkpoint separating the village from East Jerusalem, residents can be subjected to fines and/or arrest if they are found in East Jerusalem without permits.

planning regime in Area C, An Nabi Samuel faces the challenge of Israeli authorities having designated the area a protected national park. Hence, no new construction is permitted. As a result, the only school — a one-room structure (16 m^2) serving 10 students — cannot expand to provide adequate educational space. ICA issued a demolition order against a metal structure set up by the school to serve as a cover for the backyard. Through the Humanitarian Emergency Response Fund, an NGO implemented a project during the second half of 2011 through which it renovated the school (changing the window and door, building a fence around it with a gate to protect students from the main road and adding a sanitation unit). In response, Israeli authorities have issued a demolition order against the newly built fence. Israeli policies in An Nabi Samuel may constitute violations of international human rights law, among others, including with regard to the rights of Palestinians to freedom of movement and to own property. An Nabi Samuel is 1 of 16 Palestinian communities facing a similar situation.[36]

III. Recommendations

A. The situation in Gaza

47. **The Government of Israel should fully lift the blockade of Gaza, using means to address security concerns that do not violate the human rights of Gazans. The lifting of the blockade should include permitting the exportation of goods, should ensure that all necessary reconstruction materials can be delivered and should facilitate the movement of people to and from Gaza.**

48. **The Government of Israel should review methods used by IDF to enforce access restrictions on land and sea in Gaza. The methods should be consistent with Israel's international legal obligations and should not include the use of live ammunition against unarmed civilians. The Government of Israel should adopt measures that effectively ensure that any attack by IDF respects the principles of conduct of hostilities, namely, distinction, proportionality and precaution.**

49. **Palestinian armed groups must comply with international humanitarian law and immediately cease the indiscriminate firing of rockets and mortars. As a matter of priority, they should ensure that no such activities are carried out in densely populated areas.**

B. The situation in the West Bank including East Jerusalem

50. **The Government of Israel should take all necessary measures to prevent incidents of excessive use of force. This should include a review of regulations on the use of weapons and crowd-control means in operations carried out by all Israel security forces, to ensure that these regulations are in line with Israel's international legal obligations.**

[36] For more information see B'Tselem, http://www.btselem.org/freedom_of_movement/20080706_severing_nabi_samwil_from_wb.

51. The Government of Israel must respect the right of individuals to peaceful assembly in the West Bank, including East Jerusalem. The use of force against peaceful protesters should cease immediately, and Military Order 101 must be repealed or modified to ensure compliance with international human rights law.

52. Injuries and deaths caused by Israeli security forces should be fully investigated in line with international standards of promptness, independence, impartiality and thoroughness. Individuals found responsible must be held accountable and victims compensated.

53. The Government of Israel should commission an independent and thorough review of its policy of administrative detention, with a view to terminating the policy.

54. The Government of Israel should treat Palestinian children in detention with due consideration to their age, in accordance with international standards.

55. Israeli policies resulting in the forcible transfer of civilians within and from the Occupied Palestinian Territory, including the revocation of residency rights of Palestinians from East Jerusalem, evictions, home demolitions and the planned transfer of Bedouin communities, should be terminated immediately. Israeli planning and zoning policies and practices should be immediately modified to ensure adequate housing for all Palestinian residents of Area C and East Jerusalem.

56. The Government of Israel should fully comply with the advisory opinion of the International Court of Justice on the *Legal Consequences of the Construction of a Wall in the Occupied Palestinian Territory*, in particular by immediately halting the construction of the Wall and dismantling or rerouting the constructed section to the Green Line.

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Follow-up to the outcome of the Millennium Summit

Note by the Secretary-General transmitting the report of the Director-General of the World Health Organization on options for strengthening and facilitating multisectoral action for the prevention and control of non-communicable diseases through effective partnership

Summary

The present report, prepared by the World Health Organization pursuant to General Assembly resolution 66/2, sets out options for strengthening and facilitating multisectoral action for the prevention and control of non-communicable diseases through effective partnership. The report gives an overview of existing partnerships in this area, their lessons learned and key elements for successful approaches, and proposes five models for global partnerships against non-communicable diseases.

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I. Introduction

1. The present report is submitted pursuant to the annex to General Assembly resolution 66/2, in which the Assembly requested the Secretary-General, in close collaboration with the Director-General of the World Health Organization (WHO) and in consultation with Member States, United Nations funds and programmes and other relevant international organizations, to submit to it by the end of 2012, at its sixty-seventh session, options for strengthening and facilitating multisectoral action for the prevention and control of non-communicable diseases[1] through effective partnership.

2. The report reflects the input gathered in accordance with WHO Executive Board resolution EB130.R7, by which the Board requested the Director-General of WHO to develop the WHO input called for in the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases. A progress report and a timeline were submitted to the Sixty-fifth World Health Assembly (document A65/7). Accordingly, the present report builds on the discussions at the Sixty-fifth World Health Assembly.

3. While Governments have the primary role and responsibility to respond to the challenge of non-communicable diseases, the complexity of the challenges posed by such diseases, in terms of both improving health outcomes from and reducing exposure to risk factors for non-communicable diseases, necessitates efforts from across Government, namely, "multisectoral action" (see examples in table 1 below).

4. The use of the term "multisectoral" is paired deliberately with the emphasis on partnerships to recognize the critical contributions needed from stakeholders beyond Governments. The present report refers to such collaborations as multi-stakeholder partnerships.

5. As non-communicable diseases threaten the populations and fiscal health of all nations, greater action in all countries and by all stakeholders remains imperative. The outcome document of the United Nations Conference on Sustainable Development, entitled "The future we want" (General Assembly resolution 66/288, annex) acknowledges that the global burden of non-communicable diseases constitutes one of the major challenges for development today.

II. Increasingly, Governments in developing countries are making efforts to address non-communicable diseases, but growing awareness of the challenge of epidemic proportions and its socioeconomic developmental impacts has rarely translated into multisectoral action at the scale required

6. Most premature deaths from non-communicable diseases are preventable by influencing public policies in sectors outside health rather than by making changes in health policy alone.[2] Quick gains against the non-communicable disease epidemic can be achieved through modest investments in a package of core interventions that reduce the exposure of populations and individuals to the risk factors for such

[1] Principally cardiovascular diseases, cancers, chronic respiratory diseases and diabetes.

[2] For further details on this issue, see documents A/65/362 and A/66/83.

diseases and strengthen health care for people with them. Widespread implementation of these interventions requires the active engagement of sectors beyond health and a whole-of-Government approach. Accordingly, the Political Declaration on non-communicable diseases offers a paradigm shift in thinking about such diseases as an issue that cannot be addressed by one sector alone and focuses on cross-sectoral priority actions for Governments. These include the following:

- **Advocacy for action on non-communicable diseases**. Build and disseminate information about evidence base on the relationship between non-communicable diseases, development, environmental sustainability, and peace and security based on national situations
- **A holistic approach**. Integrate policies and programmes relating to non-communicable diseases into health-planning processes and the national development agenda.
- **Partnerships**. Establish and strengthen national multisectoral policies and plans for the prevention and control of non-communicable diseases, with special emphasis on:
  - Setting national targets and indicators for the prevention and control of non-communicable diseases and measuring results
  - Reducing exposure to the common risk factors for non-communicable diseases
  - Promoting access to primary health-care interventions for non-communicable diseases
- **Sustainability**. Increase domestic budgetary allocations for combating non-communicable diseases and explore viable financing options through voluntary innovative financing mechanisms, including taxation on tobacco and alcohol.

7. A global survey conducted by WHO in 2009-2010 shows that while 65 per cent of countries have written policies targeting one or more non-communicable diseases or their risk factors, only 31 per cent have operational programmes with dedicated funding. While poorer countries are increasingly less likely to fund and implement programmes, self-reinforcing political commitments from leaders in developing countries to address non-communicable diseases have gained steam.

8. In addition, policy responses tend to be piecemeal rather than comprehensive and integrated. Surveys of 158 countries conducted in 2000 and 2010 showed a moderate increase in integrated policies (52-67 per cent) and in specific policies, such as cardiovascular disease (34-65 per cent) or tobacco (39-85 per cent). However, fewer than half of countries with policies report that policies are operational with dedicated budgets. Therefore, comprehensive responses in all sectors for the prevention and control of non-communicable diseases need to be strengthened and resources should be allocated to implementation with a focus on the rising risks and burden of such diseases.

III. Member States need to lead multisectoral action and multi-stakeholder partnerships

9. At the World Health Assembly in 2012, Governments adopted a voluntary global target to reduce premature mortality from non-communicable diseases by 25 per cent by 2025 — the "25 by 25" voluntary global target. Additional voluntary global targets will be considered at a formal meeting of Member States and United Nations system agencies to be convened by WHO in November 2012.

10. In May 2013, the World Health Assembly will consider a 2013-2020 global action plan on non-communicable diseases, comprising a set of actions to achieve a global target of a 25 per cent reduction in premature mortality from non-communicable diseases by 2025, as well as additional voluntary global targets. The plan will also guide the development of national indicators and targets and place special emphasis on how Governments can galvanize the implementation of interventions through a meaningful multisectoral response.

11. Despite the many interventions that exist for the prevention and control of non-communicable diseases, even the wealthiest countries have to choose which are implemented, given limited resources. In preparation for the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, WHO identified a set of evidence-based "best buy" interventions with compelling evidence for cost-effectiveness, feasibility, affordability and appropriateness to implement within the constraints of local health systems.[3] Many require a multisectoral approach for optimal implementation.

12. Member States repeatedly have recognized that national policies and supranational practices by sectors beyond the area of health have a major bearing on non-communicable diseases and their risks. Countries have called for multisectoral action, including whole-of-government, whole-of-society and health-in-all-policies approaches across relevant sectors. Greater gains can be achieved working with many other sectors, as shown in table 1 below.

[3] See WHO, *Scaling up action against NCDs: How much will it cost?* (Geneva, 2011), table 1, available at http://whqlibdoc.who.int/publications/2011/9789241502313_eng.pdf.

Table 1
Examples of cross-sectoral government engagement to reduce risk factors for non-communicable diseases[4]

Sector	*Tobacco*	*Physical inactivity*	*Harmful use of alcohol*	*Healthy diet*
Agriculture (food and agriculture system)	✓		✓	✓
Communication	✓	✓	✓	✓
Education	✓	✓	✓	✓
Energy		✓	✓	✓
Environment	✓	✓	✓	✓
Finance	✓	✓	✓	✓
Food	✓		✓	✓
Health	✓	✓	✓	✓
Housing	✓	✓		
Industry		✓	✓	✓
Justice/security	✓	✓	✓	
Legislature	✓	✓	✓	✓
Transport	✓	✓	✓	✓
Social/welfare	✓	✓	✓	✓
Sports	✓	✓	✓	✓
Trade	✓	✓	✓	✓
Urban planning		✓	✓	✓

13. Tools for multisectoral action comprise laws, regulations, policies, budgetary allocations, impact assessments and other normative and political instruments. Additionally, Governments must lead partnerships with civil society, the private sector and other stakeholders. Illustrative examples of these actions are shown in table 2 below. National plans, the global action plan on non-communicable diseases, and the global monitoring framework can provide guidance to determine the sectoral participation needed to achieve progress and remain inclusive but efficient.

[4] Adapted from: Montserrat Meiro-Lorenzo and others, "Effective responses to NCDs: embracing action beyond the health sector", World Bank, 2011, available at http://siteresources.worldbank.org/HEALTHNUTRITIONANDPOPULATION/Resources/281627-1095698140167/EffectiveResponsestoNCDs.pdf.

Table 2
Examples of the potential health effects of multisectoral action

Risk factor for non-communicable diseases	*Sectors involved (examples)*	*Examples of multisectoral action*	*Desired outcome*
Tobacco use	– Legislature – Stakeholder ministries across government, including ministries of agriculture, customs/revenue, economy, education, finance, health, foreign affairs, labour, planning, social welfare, state media, statistics, and rade – Civil society	– Full implementation of WHO Framework Convention on Tobacco Control obligations through coordination committees at the national and subnational levels	– Implementation mechanisms in place based on country priorities – Reduced tobacco use and consumption, including second-hand smoke exposure and reduced production of tobacco and tobacco products
Physical inactivity	– Ministries of education, finance, labour, planning, transport, urban planning, sports, and youth – Local government – Private sector – Civil society	– Urban planning /re-engineering for active transport and walkable cities – School-based programmes to support physical activity – Incentives for work site healthy-lifestyle programmes – Increased availability of safe environments recreational spaces – Mass media campaigns	– Increased physical activity
Harmful use of alcohol	– Legislature – Ministries of trade, industry, education, finance, justice – Local government – Private sector – Civil society	– Tax increases – Bans on alcohol advertising – Restricted access to retailed alcohol – Reduced drunk driving	– Reduced harmful use of alcohol
Unhealthy diet	– Legislature – Ministries of agriculture, trade, industry, education, urban planning, energy, transport, social welfare, environment – Private sector – Civil society	– Reduced amounts of salt, saturated fat and sugars in processed foods – Eliminate industrially produced trans-fats in foods – Controlled advertising of unhealthy food to children – Promotion of fruit and vegetable intake – Offer of healthy food in schools and other public institutions and through social support programmes – Economic interventions to drive food consumption (taxes, subsidies) – Food security	– Reduced use of salt, saturated fat and sugars – Substitution of healthy foods for energy-dense micronutrient-poor food – Reduced obesity

14. WHO, the World Bank and others have identified various multisectoral approaches and actions relevant to the prevention and control of non-communicable diseases. They recommend the following:

- Using a whole-of-Government approach
- Ensuring ongoing political leadership to ensure accountability
- Responsible stewardship and management of conflict of interest
- Ensuring sustainable financing, discussed in section IV below, in the context of both multisectoral and multi-stakeholder partnerships
- Developing a sustainable workforce, for health and within supporting non-health services, drawing on a wide range of disciplines given the complexity of issues relating to non-communicable diseases: advertising, anthropology, business, economic, food and agricultural system, law, management, psychology, trade and urban planning
- Ensuring access to safe, effective, quality medicines and diagnostic and other technologies. Equitable access requires rational selection, affordable prices, sustainable financing and reliable systems
- Promoting the development and use of impact assessment, which can assist in systematically assessing the health effects of policies external to the health sector and promoting accountability.

15. There are existing partnerships against non-communicable diseases. In a survey conducted by WHO in 2010, 86 per cent of countries reported having some form of partnerships or collaborations for implementing key activities relating to non-communicable diseases. Most countries (76 per cent) engage in collaboration in the form of a cross-departmental or ministerial committee. Fewer countries have interdisciplinary committees (68 per cent) or joint task forces (59 per cent). Non-governmental organizations (NGOs), community-based organizations and civil society together form a stakeholder in the partnerships/collaborations in the majority of countries (82 per cent). Collaborations with other, non-health government ministries are also common (80 per cent of countries), as is the case with academia (72 per cent) and United Nations system agencies (68 per cent). Private sector entities are the least common stakeholder (59 per cent), although they are far more often stakeholders in upper-middle-income and high-income countries (70 per cent) than in low-income countries (37 per cent). Collaborations most often address tobacco use (83 per cent of countries), diabetes (81 per cent), unhealthful diet (77 per cent), cancer (77 per cent), physical inactivity (75 per cent) and hypertension (72 per cent).

IV. Country-led action can be advanced by more and better partnerships at the regional and global levels

Global activities should be designed to better support Member States

16. Non-communicable diseases are at the top of requests from developing countries for policy advice, technical assistance and capacity-building. An analysis of 144 WHO country cooperation strategies in 2012 found that 136 Member States requested support for the design and/or implementation of national multisectoral efforts to address non-communicable diseases. Yet, those requests cannot be adequately addressed and many commitments remain unfulfilled. A new and more holistic approach is needed to address this deficit and leverage the knowledge

generated on successful approaches and lessons learned in responding to non-communicable diseases in order to realize the future we want for all. There is a need to address the multisectoral political, technical and operational issues and support Governments' diverse roles as strategists, financiers, stewards and implementers. Global efforts must focus on creating a conducive environment, providing tools and mobilizing resources, and also evaluating and promoting the sharing of good practices between countries and monitoring action and impact to ensure effectiveness and accountability. Efforts should also limit harmful elements in that context, such as the commercial practices around tobacco. Regional economic and development cooperation organizations can also contribute to national action, including in the context of trade negotiations. Intergovernmental bodies active in non-health sectors, such as the Committee on World Food Security and the Human Rights Council, can also contribute.

To date, non-communicable disease partnerships have been relatively small and piecemeal

17. There are relatively few documented global partnerships against non-communicable diseases to date. From 2009 to 2011, the WHO Global Non-communicable Disease Network, NCDnet,[5] brought together a range of actors under a voluntary collaborative arrangement comprising donors, philanthropic foundations, United Nations system agencies, intergovernmental organizations, international financial institutions, NGOs and the private sector. NCDnet aimed to coordinate the activities of various stakeholders to facilitate a political, social and public health movement in support of the implementation of the WHO 2008-2013 Action Plan for the Global Strategy for the Prevention and Control of Non-communicable Diseases.[6] With recent developments, including the Political Declaration on non-communicable diseases, the outcome document of the United Nations Conference on Sustainable Development, the ongoing work on the global monitoring framework and targets for non-communicable diseases and the 2013-2020 global action plan, NCDnet has become insufficient in scope and scale. Other multisectoral global efforts that are relevant for non-communicable diseases — such as for nutrition, physical activity, harmful alcohol use and tobacco control — also offer opportunities on which to build.

18. Lessons can be learned from other global groups. The NCD Alliance[7] highlights the importance of bringing together groups from previously isolated disease- or risk factor-focused spheres. The Bloomberg Initiative to Reduce Tobacco Use[8] and the Gates Foundation-funded WHO project to reduce tobacco use in Africa[9] show that tight accountabilities against well-defined targets can accelerate progress.

19. Future global activities need to be oriented towards and responsive to the needs of Member States, with an emphasis on technical support, including integrating with wider health-system strengthening and universal coverage agendas. For example, the European Union provides support for the implementation of the

[5] www.who.int/ncdnet.

[6] Available at http://www.who.int/publications/en/.

[7] www.ncdalliance.org.

[8] http://www.who.int/tobacco/communications/highlights/bloomberg/en/index.html.

[9] http://www.who.int/tobacco/communications/events/who_centre_tobacco_control_africa/en/.

WHO Framework Convention on Tobacco Control[10] through assistance to developing countries based on joint needs assessments and in accordance with the principles of national ownership and political commitment.

Lessons from existing global health partnerships can be applied at the country and global levels to develop strong collaborative efforts against non-communicable diseases

20. Reviews of existing global health-related partnership models point to a range of lessons learned that can inform the design and expansion of partnerships against non-communicable diseases.[11,12,13,14] For example, it takes time to develop partnerships with adequate scale and scope to have impact. Models should be able to evolve to respond to needs and opportunities. While some initiatives apply a phased approach, others are founded with broad and comprehensive mandates. The number and structures of partnerships often evolve to match changing needs and conditions. For non-communicable diseases, this suggests a simultaneous need to advocate and establish a culture of responding to the challenge of such diseases that spurs countries to seek solutions.

21. Furthermore, partnerships' functions and objectives should determine their structural arrangements. Partnerships with significant financing roles tend to formalize governance structures, decision-making roles and accountabilities. Coordinating bodies, such as task-focused networks, often require less formal governance structures to achieve results while providing flexibility and limiting transaction costs. Some global health partnerships have recognized the significant contributions that result from the inclusion of communities and individuals affected by the disease targeted.

22. Other determinants that enable partnership successes for public health include:

- Demonstrating a clear added value for public health
- Having a clear goal that concerns a priority area of the work of WHO
- Being guided by the technical norms and standards established by WHO
- Supporting national development objectives
- Ensuring the appropriate and adequate participation of stakeholders
- Clear roles of partners

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[10] United Nations, *Treaty Series*, vol. 2302, No. 41032.

[11] WHO, Report by the Secretariat on partnerships, (World Health Assembly document A63/44).

[12] K. Buse and S. Tanaka, "Global public-private health partnerships: lessons learned from ten years of experience and evaluation", *International Dental Journal*, vol. 61(Supp. 2), pp. 2-10 (August 2011).

[13] Bill & Melinda Gates Foundation, "Developing successful health alliances", 2002, available at https://members.weforum.org/pdf/Initiatives/GHI_2003_GlobalHealthAlliances.pdf, accessed 10 October 2011.

[14] Karen Caines and others, "Assessing the impact of global health partnerships", Department for International Development Health Resource Centre, available at http://www2.ohchr.org/english/issues/development/docs/WHO_synthesis.pdf, accessed 10 October 2011.

- Frequent evaluation of transaction costs related to the partnership, along with the potential risks and benefits
- Pursuit of the public-health goals takes precedence over the special interests of participants
- Having an independent external evaluation and/or self-monitoring mechanism.

23. The immediate challenge is to ensure transformative change through sustained political will and government leadership in addressing non-communicable diseases, which are critical in order to reach the necessary levels of multisectoral cooperation, regulatory and legislative action, policy coherence and funding and the long-term commitment required to realize the future we want for all. Political will is required to create a national coordination body — ideally reporting to the Head of State or Government — and to demand and oversee a national multisectoral plan and targets, which in turn is critical to determine the shape and membership of cross-sectoral work. Political will is also critical to provide adequate, sustained and predictable financing. Political leadership underpins sustained accountability for results.

24. The emphasis on accountability for global health activities has never been greater. To improve efficiency and effectiveness, especially in the setting of scarce resources, independent and regular evaluation is essential. Different partnerships rely on different models — from independent auditors, to external reviews commissioned by the organization itself, to watchdog-type reports from civil society or donors — and these are often additive or complementary. There are opportunities for contributions to accountability from platforms including the General Assembly the World Health Assembly and civil society.

25. There will be opportunities to build on structures of other global health partnerships, such as those regarding HIV, tuberculosis, malaria, reproductive health and child health. For example, the GAVI Alliance is increasingly contributing to efforts to reduce cancer-related deaths from hepatitis B and deaths from cervical cancer.

26. Furthermore, the work of the WHO Framework Convention on Tobacco Control, under the guidance of the Conference of the Parties, can contribute to strengthening the legal, administrative and advocacy dimension of the global response to non-communicable diseases.

Multisectoral and multi-stakeholder to build momentum

27. On the basis of an analysis of other health-related efforts, WHO has identified a key set of functions that contribute to an enabling environment for implementation:

- **Coordination mechanisms**. Collaborative mechanisms can support and assemble the relevant sectors and actors to plan, design, implement and monitor programmes on non-communicable diseases. Mechanisms also are needed to convene and harness the energies of other stakeholders, including civil society, philanthropic organizations and the private sector, as appropriate. In developing countries, they can assist in donor coordination
- **Advocacy, awareness-raising and accountability**. Communication is needed at the global and local levels, with messages ranging from promoting non-communicable disease issues in health planning and development agendas

for political decision makers to target the populations and individuals at risk and to build literacy around non-communicable disease prevention and control. Advocacy efforts can benefit from the contributions of civil society and others, including those affected by such diseases. Advocacy and implementation will benefit from mechanisms promoting accountability, underpinned by active monitoring and evaluation to create the evidence base around progress

- **Financing and resource mobilization**. At the country level, most financing will come from domestic sources; however, for global activities in support of national efforts and to supplement domestic resources, there are other sources that may contribute, including innovative financing, multilateral financing, bilateral sources and private sector and/or non-governmental sources

- **Capacity-building and technical support**. For many countries, the immediate priorities are capacity assessments, the development of national plans and the introduction of consumption taxes and other budgetary reforms to fund programmes. Structures for capacity-building can vary from virtual knowledge hubs to hands-on training programmes and technical engagements

- **Product access and market shaping**. Market shaping activities can range from pooled procurement of health commodities or innovative mechanisms to sustainably reduce prices. to enabling strategies such as patent pools and financing mechanisms. Some focus on strengthening supply chains, safeguarding quality and increasing the points of availability. Other partnerships can promote appropriate uptake and individual or community awareness

- **Product development/innovation**. Public-private partnerships can develop new medicines, vaccines and diagnostics to fill product gaps. They may support new or improved information and communications technologies to reach clinical services, health-care workers, communities or patients.

Applying the key functions of potential partnerships for non-communicable diseases at the national, regional and global levels

28. At the national level, the balance of key functions of partnerships will vary according to national settings and may include the following:

(a) Consultative coordinating platform:

- Exercise a leadership and a coordination role in promoting and monitoring national multisectoral action against non-communicable diseases in relation to the work of Government departments, civil society and the private sector

- Establish a high-level multisectoral mechanism for planning, guiding, monitoring and evaluating enactment of the national policy with the effective involvement of sectors outside the area of health

- Conduct a comprehensive assessment of non-communicable disease characteristics and the scale of the problems they pose, including an analysis of the impact of the policies of different Government sectors

- Promote, establish or support and strengthen, by 2013, as appropriate, multisectoral national policies and plans for the prevention and control of non-communicable diseases

- Establish effective partnerships for the prevention and control of non-communicable diseases, and develop collaborative networks, involving key stakeholders, as appropriate
- Participate actively in regional and global networks for the prevention and control of non-communicable diseases

(b) Advocacy and awareness:

- Strengthen the capacity of individuals and populations to make more healthful choices and follow healthful lifestyle patterns
- Raise public awareness of the increasing magnitude of the public-health and development problems posed by non-communicable diseases, and the fact that tackling the determinants of and risk factors for such diseases has the potential to be a significant method of prevention
- Promote the capacity-building of non-communicable disease-related NGOs at the national level to establish a social movement on non-communicable diseases and realize their full potential as partners in the prevention and control of such diseases
- Integrate non-communicable diseases into the discussions on the post-2015 United Nations development agenda

(c) Financing and resource mobilization:

- Increase and prioritize budgetary allocations for addressing non-communicable diseases
- Support the development of voluntary innovative financing mechanisms, including the potential to increase taxation on tobacco and alcohol

(d) Capacity-building:

- Strengthen national capacities to develop national targets and indicators based on national situations, implement a core set of interventions and design and implement national multisectoral policies and plans for the prevention and control of non-communicable diseases
- Review and strengthen, when necessary, evidence-based legislation, together with fiscal and other relevant policies that are effective in reducing the risk factors for non-communicable diseases

(e) Product access:

- Enhance access to essential medicines and affordable medical technology for the prevention and control of non-communicable diseases, building on WHO programmes promoting both good-quality generic products and the improvement of the procurement, efficiency and management of medicine supplies

(f) Product development and innovation:

- Invest in research as part of national programmes for the prevention and control of non-communicable diseases
- Encourage the establishment of national reference centres and networks to conduct research on socioeconomic determinants, gender, the cost-

effectiveness of interventions, affordable technology, health-system reorientation and workforce development.

29. At the global level, the Political Declaration on non-communicable diseases reaffirms the leadership and coordination role of WHO in promoting and monitoring global action against such diseases in relation to the work of other relevant United Nations system agencies, development banks and other regional and international organizations to address them in a coordinated manner. WHO recognizes that leadership requires many activities, which include convening and coordinating diverse stakeholders to capture a wider range of skills and resources. Key functions at the global level may include the following:

(a) Global consultative coordinating platform:

- Global stocktaking
- Exchange knowledge based on global stocktaking for coordination and new partnerships
- Exchange best practices
- Facilitate technical assistance

(b) Advocacy and awareness:

- Forge political alliances to support developing countries
- Integrate non-communicable diseases into the post-2015 United Nations development agenda, Group of Twenty, and so forth
- Build public awareness

(c) Financing and resource mobilization:

- Cultivate adequate sustainable resources for needs
- Support the development of financing mechanisms

(d) Capacity-building:

- Translate "how-to" tools for the non-communicable disease "best buys" into action
- Mobilize support across the United Nations system agencies and beyond
- Establish a roster of international experts on non-communicable diseases

(e) Product access:

- Support market shaping, including pricing, procurement, quality support and distribution, where appropriate
- Support the implementation of WHO essential medicines
- Develop partnerships for access

(f) Product development and innovation:

- Identify product/technology gaps
- Support development partnerships through financing, and so forth.

30. Various other actors can join a global platform to build momentum towards the 25 by 25 voluntary global target and additional voluntary global targets, including United Nations system agencies, development banks and other regional and international organizations, philanthropic foundations, NGOs and private sector platforms. Global coordination will be critical to ensure that all voluntary global targets are achieved, support existing efforts and catalyse new ones.

31. In the Political Declaration on non-communicable diseases, world leaders called on the private sector to strengthen its contribution to non-communicable disease prevention and control by taking concrete measures. The private sector can bring comparative advantages, for example, to strengthen information, communications and logistical systems for the delivery of health-related goods and services; to facilitate healthful policies relating to non-communicable diseases in urban planning; to promote healthy communities and raise consumer awareness; and to develop innovative solutions for gaps in terms of the goods and services required.

32. Examples[15] of United Nations system agencies supporting global and national activities include the recent joint letter from the Heads of the United Nations Development Programme (UNDP) and WHO addressed to United Nations country teams, proposing to integrate, according to country context and priorities, non-communicable disease prevention and control within the United Nations Development Assistance Frameworks. WHO and other United Nations system agencies are exploring a task force on non-communicable diseases, which would report to the Economic and Social Council. The World Bank has committed to providing wide-ranging support for developing countries to improve their development and health outcomes — both in relation to the unfinished Millennium Development Goals agenda and the challenges posed by non-communicable diseases.

33. International agencies, philanthropic and development donors and NGOs need to work together to enhance their support for country-level multisectoral action. There are opportunities for North-South, South-South and triangular partnerships. Donors and other technical agencies should ensure that their activities are in line with the Paris Declaration on Aid Effectiveness and the Accra Agenda for Action. For example, the evolving framework of South-South and triangular cooperation under the WHO Framework Convention on Tobacco Control addresses regional- and subregional-specific implementation challenges through the exchange of knowledge, legal and technical expertise.

V. There is a range of options for national and global partnerships

34. The desired functions and objectives of national and global partnerships should influence their structural arrangements. While there should be policy coherence, the diversity of contexts and challenges within and among countries

[15] For additional contributions from other United Nations system agencies, see the report of the first Meeting of United Nations Funds, Programmes and Agencies on the Implementation of the Political Declaration of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases (New York, 8 December 2011), available at http://www.who.int/nmh/events/2011/UN_NCDs_Report.pdf.

should also be considered. Two elements should be seen as common. First, core values, principles and standards derived from the internationally adopted WHO normative frameworks on non-communicable diseases should be explicitly integrated into any option for national and global partnerships. In addition, the response to non-communicable diseases has a number of important characteristics that should influence the shape of partnerships, including: the centrality of national leadership, the multisectoral nature and the need to involve and coordinate a myriad of actors, and the relatively nascent response that is currently largely unfunded. Future decisions on options should consider their cost and cost-effectiveness, their ability to promote multisectoral action and multi-stakeholder engagement and whether their likely impact will match the needs of non-communicable diseases.

At the country level, Governments need to determine which bodies will drive their national responses to non-communicable diseases and how to empower them

35. The response to non-communicable diseases shares certain principles across settings, even as national programmes require specific tailoring. First, countries need to determine how to designate a lead body or agency. Some countries establish a core group reporting to the Head of State. Some create a national agency or multisectoral commissions for health promotion and prevention, while others strengthen structures within the ministry of health.

36. National non-communicable disease leads in countries then have to determine to what extent they will act as strategists and stewards, as opposed to acting as actors and implementers. They need to plan pathways for regulatory and legislative reform to mitigate the risk factors for non-communicable diseases and to support the treatment and care of such diseases. They need to assess their capacity for change and to identify and marshal resources to fill gaps — whether technical, financial or structural. Finally, they need to identify programmes — such as reproductive health, nutrition, tobacco, HIV and tuberculosis, and mental health programmes — in which they can include non-communicable diseases.

37. With these assessments in mind, non-communicable disease leads must prioritize how to reach out to relevant sectors within Government and to stakeholders who might be interested in partnering and establish structures for engagement.

38. In parallel, countries can choose how to reinforce whole-of-Government approaches for non-communicable diseases; for example, by enshrining them in United Nations Development Assistance Framework agreements, poverty reduction strategies, Millennium Development Goals programmes and donor agreements.

39. WHO, other relevant United Nations system agencies, development banks and other regional and international organizations will build the capacity of Member States in establishing a high-level multisectoral mechanism for planning, guiding, monitoring and evaluating the enactment of national policy with the effective involvement of sectors outside the area of health.

Global collaborative efforts should promote and accelerate country action

40. Existing global health partnerships illustrate a range of models that are being used to support countries in implementing health priorities. While existing partnerships vary in size, scope and formality, each has a central coordinating mechanism that convenes stakeholders (see figure below).

An illustrative spectrum of global health partnerships

Example	UN Road Safety Collaboration	PMNCH	Stop TB Partnership	GAVI Alliance	GF
Secretariat (FTE)	Less than 10	Around 10	Around 10	179	Hundreds
Secretariat budget (USD per year)	3 million	10 million	89 million	79 million	209-300 million
Funds under management	Not directly	Millions for country grants	Millions for country grants	Billions	23 billion in approved funding
Resource mobilization/ innovative financing	• (RS Facility) • (FIA Fund) • (RS Fund) • Funding for the decade campaign	• Task Force on Global Financing Architecture	• Global Drug Facility • TB REACH • UNITAID	• Replenishment • IFFIm • AMC • Matching Fund	• Replenishment • Debt 2 Health • (Product (Red))
Capacity building/technical assi nce	• WHO, other UN agencies, World Bank	• MNCH portal • Technical publications	• TBTEAM & Green Light Committee	• Business plan support to WHO, UNICEF, and other partners	• HSS platform • Grants
Products access/development		• Commission on Commodities	• Global Drug Facility • TB REACH	• AMC • Phase IV studies	• AMFM

Abbreviations: IFFIM, International Financing Facility for Immunization; AMC, advanced market commitment; ADIP, accelerated development and introduction plan; AVI, Accelerated Vaccine Introduction Initiative; HSS, Health-Systems engthening Platform; GF, Global Fund to Fight AIDS, Tuberculosis and Malaria; AMFM, affordable medicines acility — malaria; PMNCH, Partnership for Maternal, newborn and Child Health; MNCH, maternal, neonatal, and child health.

41. Some features of non-communicable diseases imply that the partnerships focused on such diseases will be different. While some existing partnerships were formed around the distribution of external funding, non-communicable diseases will predominantly require domestic funding. Also, most partnerships are focused primarily on mobilizing the health sector and enhancing health services around vertical programmes, rather than on multisectoral action to catalyse regulatory, legislative and health-system reform, as is required for non-communicable diseases. Another, relatively new, example is related to treaty work under the WHO Framework Convention on Tobacco Control, the first global health treaty. With the combined funding from voluntary assessed contributions as its regular budget, and extrabudgetary contributions from the parties, its workplan is adopted by the Conference of the Parties and executed by the Convention secretariat.

42. Using this analysis as an illustrative guide, five broad models are proposed as options for the consideration of global partnerships against non-communicable diseases. These models may represent a progression over time, reflecting the progress — or lack thereof — made against the challenges of the non-communicable disease epidemics.

Option 1: aligned independent efforts

43. This model essentially describes an enhancement of the state of efforts against non-communicable diseases to date. Activities have evolved organically, largely without coordination or shared strategy. The implementation of global strategies on alcohol and diet, nutrition and exercise has been patchy, but improving. The implementation of the WHO Framework Convention, as reflected in the implementation reports of the parties, shows steady progress internationally. There are a number of disease- or risk-factor-specific collaborations, but few cross-cutting ones. Very few partnerships tackle the development of health systems comprehensively, meaning that there are limited options for partnerships with which programmes on non-communicable diseases might expand. However, the implementation experience of the WHO Framework Convention is important and acknowledged for its contribution to strengthening multisectoral mechanisms and their relevance in ensuring a whole-of-Government approach at the country level.

44. Generally, interested actors determine the timing and extent of their activities against specific non-communicable diseases or their risk factors, without concerted advocacy to accelerate action or to ensure that countries' requests for assistance are answered.

45. Overall, this approach would need considerable attention to catalyse partnerships or create the momentum to set a trajectory towards the 25 by 25 voluntary global target.

46. For this organic model to gain greater traction without a significant investment of new resources, WHO could host a forum or series of forums and invite interested parties to express commitment and to seek partnerships in support of the global action plan on non-communicable diseases 2013-2020. Such a meeting could seek to accelerate action by blending the characteristics of a pledging conference and a matchmaking event. WHO could also develop an electronic notice board with the aim of helping countries to request technical assistance or support.

47. The risks of continuing with this model include that the momentum generated will be insufficient to reach the 25 by 25 target and that countries will not be able to gain access to the support that they need.

Option 2: social movement

48. To promote public awareness about non-communicable diseases and to provide the basis for converging advocacy around the links between such diseases, poverty and development, this model would entail establishing a social movement on non-communicable diseases aimed at directing national and global resources towards multisectoral policies and plans. As with HIV, social movements could advocate Government action to prevent and manage non-communicable diseases through a whole-of-society approach, including by lobbying and informing

parliamentarians. A set of principles and rules of engagement would have to be developed to unite the movement around a common agenda.

49. Stakeholders would include WHO, other relevant United Nations system agencies, development banks and other regional and international organizations, civil society and the private sector, safeguarding public health from any potential conflict of interest.

50. With a view to strengthening its contribution to a social movement on non-communicable diseases, the private sector in particular would:

- Take measures to implement the WHO recommendations to reduce the impact of the marketing of unhealthful foods and non-alcoholic beverages to children, taking into account existing national legislation and policies
- Consider producing and promoting more food products consistent with a healthful diet, including by reformulating products to provide more healthful options that are affordable and accessible and that follow relevant nutrition facts and labelling standards, including information on sugars, salt and fats and, where appropriate, trans-fat content
- Promote and create an enabling environment for healthful behaviours among workers, including by establishing tobacco-free workplaces and safe and healthful working environments through occupational safety and health measures, including, good corporate practices, workplace wellness programmes and health insurance plans
- Work towards reducing the use of salt in the food industry to lower sodium consumption
- Contribute to efforts to improve access to and the affordability of medicines and technologies in the prevention and control of non-communicable diseases.

Option 3: coordinated network

51. There are a number of more recent partnerships that have looser "networked" structures in and around which activities tend to be collaborative, time-bound and purpose-driven in nature. Examples include the United Nations Global Road Safety Collaboration and the Partnership for Maternal, Newborn and Child Health. An evolving and dynamic framework is emerging in relation to the work of the Ad Hoc Inter-Agency Task Force on Tobacco Control.

52. Despite having relatively small secretariats and only catalytic budgets, both organizations use their convening platforms to promote a range of supportive financing and implementation-oriented partnerships. Around them are larger financing bodies. They have strong relationships with United Nations system agencies, and WHO hosts their secretariats.

53. A number of agile global partnerships, alliances and results-oriented collaborative arrangements could be established on non-communicable diseases. This would require strengthening the existing arrangements and establishing new ones, linking them through a relatively informal, networked approach.

54. The immediate first step is to build a central hub that can catalyse more partnerships in successive rings of spokes. A neutral convening platform should ensure that advocates are not confined to technical, disease or risk-factor silos that

would make it harder for countries to adopt comprehensive and integrated responses. It can also invite a wide range of stakeholders to engage.

55. A global coordination mechanism would need to conduct and enable global-level advocacy with some specific goals: maintaining non-communicable diseases on the global agenda; encouraging regional and national action; monitoring and communicating progress on the 25 by 25 voluntary global target; and encouraging resource mobilization from domestic, external, and innovative sources to fulfil the advocacy and implementation requirements at all levels.

56. The coordinating mechanism could evolve to deliver additional functions — such as financing, accountability and product access — or it could catalyse aligned partnerships to do so. For non-communicable diseases, a hub-and-spoke model working through a network of partners and satellite partnerships could begin with a very informal structure and a few partners, but be tasked to advocate for and provide technical support to countries to make optimal investments in their national responses.

Option 4: a loosely coordinated network around a social movement on non-communicable diseases

57. This model would essentially be a merger of options 1, 2 and 3. The global response requires an ability to evolve. For the short term, this suggests that loose, rather than formalized, arrangements between a global coordination mechanism (a "hub") and supporting multi-stakeholder partnerships and work streams ("spokes") are most likely to achieve this goal — while being imminently affordable, with manageable transaction costs, a high degree of inclusivity and flexibility focused on specific functions and outcomes.

58. Given the currently resource-constrained environment and the need to engage partners through shared work streams, the global response to non-communicable diseases should be progressively built around a global convening platform or hub. While momentum is gathered, the initial structure should be loose and focused on those "spoke" functions that are urgent and that contribute to building momentum. This does not preclude the complementary and parallel activities of others, which should be invited and encouraged.

Option 5: centralized, formalized partnership

59. There are a number of large centralized partnerships, including the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund), the GAVI Alliance, the Joint United Nations Programme on HIV/AIDS (UNAIDS), the United Nations Standing Committee on Nutrition, and the Codex Alimentarius Commission. The Global Fund and GAVI are funding mechanisms, while UNAIDS was established to coordinate the United Nations response to HIV and became an important advocate. When founded, they tended to have vertical focuses with a mindset of an emergency or limited-term response and often instigated parallel structures in countries. Over time, they have evolved in terms of approach and terms of reference. Collectively, they have caused significant changes in how global health partnerships work, working separately but alongside traditional multilateral agencies.

60. GAVI and the Global Fund have been able to mobilize large sums with the promise of taking proven interventions to the scale required and in accordance with the principle of results-based financing. The Global Fund's founding vision was of a small secretariat that could be flexible and responsive to countries. Its structure as a public-private partnership enabled unprecedented participation (including voting rights) for civil society and the private sector. It required participation from across stakeholder groups at the country level in its national governance bodies, the country coordinating mechanisms.

61. Both have catalysed the formation of innovative financing mechanisms and experimented with innovation to promote product access. GAVI has invested in outsourced efforts to build national capacity and immunization preparedness. They have supported high-profile advocacy efforts for themselves and the needs they address. UNAIDS[16] strongly promoted the importance of political engagement, as well as the participation of people affected by the disease.

62. The magnitude and urgency of the current and future burden of non-communicable diseases could evoke proposals for a large, centralized organization — perhaps a new multilateral agency or public-private partnership — in command of significant new resources to stimulate action at all levels. A single, centralized partnership would probably not be sufficient in fulfilling the diverse partnership functions — outlined earlier — required to build the momentum to achieve the 25 by 25 target. The partnership could draw authority, influence and convening power from its resource base and cross-cutting mandate. Centralized functions could support speedy decision-making, timely and transparent monitoring, and accountability.

63. A centralized partnership for non-communicable diseases would differ from preceding examples, given the importance of country leadership and the linkages with primary health care and universal coverage that will underpin sustainability and effectiveness. The current political and financial realities, the already crowded health landscape and the need to reduce excessive fragmentation of activities mean that significant preparation would be required in order to launch this option.

VI. Selected partnership models will require an enabling environment

Financing gap to support national and global action against non-communicable diseases needs to be addressed

64. At the country level, the response to non-communicable diseases requires augmented financing for ministries of health, cross-sectoral activities and their coordination, and innovative partnerships led by Governments and involving other stakeholders. The sources of financing for most countries will be primarily domestic, reflecting the long-term nature of non-communicable disease risk-factor exposure and disease. Some least developed countries may require external support for technical assistance, capacity-building and the initiation of programming.

[16] See UNAIDS, *UNAIDS: The first 10 years, 1996-2006* (Geneva, 2008), available athttp://data.unaids.org/pub/Report/2008/JC1579_First_10_years_en.pdf, accessed 19 July 2012.

Sources for such aid are generally lacking at present but could be increased through traditional and innovative financing mechanisms.

65. Fiscal policy options include taxation for products such as tobacco and alcohol as well as the consideration of subsidies and incentives. Some countries are applying similar measures for unhealthful foods. As recommended in the WHO *World Health Report 2010*,[17] raising taxes on tobacco, alcohol and other products harmful to health can contribute substantial additional funding for Governments, while directly improving population health. For example, a 50 per cent increase in tobacco excise taxes would generate an additional $1.42 billion for the 22 low-income countries for which data are available. If all of this were allocated to health, Government health spending could increase by more than 25 per cent in several countries, up to 50 per cent. Raising taxes on alcohol to 40 per cent of the retail price could have an even bigger impact. Estimates for 12 low-income countries show that consumption levels would fall by more than 10 per cent, while tax revenues would more than triple, equivalent to 38 per cent of their total health spending. Some countries are considering fiscal options to promote healthful diets, such as taxes on unhealthful foods and subsidies for healthful foods.

66. Some countries, in particular the least developed countries, lack the national capacity not only to implement the core set of non-communicable disease interventions, but also to develop sustainable models of domestic or other financing. Many have requested technical support through bilateral and multilateral channels to address technical, managerial and governance gaps — support estimated to require between $500,000 and $1 million per year per country, at least for transitional periods. Some of the most resource-constrained countries may require longer-term external support.

67. In addition, there is a need for resources at the global level to support country efforts as well as for resources to promote and sustain global political momentum, including within the post-Millennium Development Goals agenda. Experience from other global coordination mechanisms, such as those for road safety and maternal and child health, indicate yearly budgets for convening, technical support and function-focused working groups in the order of $3 million to $10 million.

68. Few resources have been available to date from either bilateral or multilateral sources, through either traditional or innovative mechanisms. To date, an estimated seven of the Organization for Economic Cooperation and Development/Development Assistance Committee (DAC) donors have committed to or expressed interest in including non-communicable diseases in their aid programmes. There is significant scope for other DAC and emerging donors to contribute. Options to support global activities could come from traditional and emerging donors, as well as from innovative mechanisms such as a solidarity tobacco contribution.[18]

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[17] WHO, *World Health Report: Health Systems Financing: The Path to Universal Coverage* (Geneva, 2010).

[18] See WHO discussion paper, "The solidarity tobacco contribution", 2011, available at http://www.who.int/nmh/events/un_ncd_summit2011/ncds_stc.pdf.

Country, regional and global non-communicable disease partnership models will require stronger approaches to governance

69. Challenges to partnerships may include competing Government, organizational and community demands, priorities and resources; the lack of a shared understanding of goals; the lack of the shaping of health goals to address other sectoral goals, objectives and programmes; conflicts over values and diverging interests (economic or otherwise); and competing programmes.

70. Conflicts of interest may arise when personal, professional, financial or business interests are not aligned with agreed public health goals.[19] Conflicts can arise from business interests, including investments, intellectual property interests, access to proprietary information or other commercial competitive advantage. They can also arise from the cultivation of favour and advantage towards the attainment of personal, professional or organizational advancement or gain.

71. The private sector comprises a myriad of different industries, corporate cultures and business models. Each influences the interests and potential conflicts of interests that a company might bring to activities to address non-communicable diseases. Therefore, identifying and managing potential conflicts of interest requires attention, particularly when corporate business models and growth rely on the promotion of the consumption of unhealthful commodities such as tobacco, alcohol and energy-dense, nutrient-poor foods and drink. The Political Declaration on non-communicable diseases particularly recognizes the fundamental conflict of interest between the tobacco industry and public health. Addressing direct and indirect forms of conflict of interest regarding tobacco is necessary, for both publicly and privately owned tobacco entities.

72. Partnerships should establish mechanisms to avoid real and perceived conflicts of interest, consistent with the types of principles established by WHO and others, including the following:

- Promoting global and national public health
- Protecting Government or organizational independence, values and credibility
- Supporting scientific evidence-based interventions
- Avoiding inequitable or inappropriate product, service or organizational endorsement
- Avoiding interaction with the tobacco and ammunitions industries
- Distinguishing between scientific exchanges/information-sharing and policy dialogues/decision-making; ensuring appropriate governance for each case.

[19] See Roll Back Malaria Partnership Conflict of Interest Policy and Procedure, available at http://www.rbm.who.int/docs/constituencies/RBMcoiPolicy.pdf.

VII. Recommendations

National commitments against non-communicable diseases need to be priorities for action

73. **Any recommendation must recognize the need for further action to be tailored in keeping with national settings and their political, technical, and operational needs.**

74. **Although most countries have some national plan against non-communicable diseases, far fewer have robust structures for enacting them. To close this gap, Heads of State and Government can appoint and resource non-communicable disease leads who report to them and are accountable for the building of needed multisectoral and multi-stakeholder partnerships, guided by national plans and targets.**

75. **At the country level, it is proposed that countries establish a high-level national multisectoral mechanism — commission, agency or task force — reporting to the Head of State or his/her delegate, to plan, guide, monitor and evaluate the enactment of the national multisectoral policy. It should ensure the effective involvement of relevant sectors. It should convene multisectoral and multi-stakeholder working groups to oversee the development, implementation and periodic evaluation of national, multisectoral non-communicable disease plans and supporting budgets.**

76. **Member States looking to apply whole-of-Government, whole-of-society and health-in-all-policies approaches can use many entry points. Many countries can incorporate the prevention and control of non-communicable diseases into national United Nations Development Assistance Framework agreements and poverty reduction strategies. Member States can review existing programmes — such as the Millennium Development Goals, nutrition, HIV/tuberculosis and reproductive health — for opportunities to link non-communicable diseases. Member States can build on experiences with other programmes to develop a single, funded national multisectoral plan accompanied by a unified set of national targets and indicators.**

77. **By the middle of 2013, non-communicable disease leads and supporting bodies should be in place, resourced and ready to respond to the global action plan against non-communicable diseases 2013-2020. It will provide guidance on implementation activities, linking the 25 by 25 voluntary global target and other voluntary global targets, the global monitoring framework and options for applying it at the country level, and the tailoring of the internationally adopted treaties and actions to individual country settings.**

A global coordinating mechanism could build structures to galvanize national development efforts against non-communicable diseases

78. **The current climate of austerity makes it challenging to design any model. Many past global health partnerships were formed in response to sizeable new finances, which made it relatively easy to attract others, typically from the highest levels — in turn augmenting the cause's momentum. Non-communicable diseases, on the other hand, suffer from a gross mismatch between the enormous needs and the financial resources mobilized. Resource**

mobilization is critical to build both the membership of the response and the response itself. The resources required are relatively small for global advocacy and technical support; implementation will be driven largely by countries' domestic budgets being directed towards non-communicable diseases, with related health-system strengthening and health financing reform. Technical support will be the "glue" binding partnerships, more than financial opportunity and oversight.

79. **Even while resources for global action are being mobilized, work must begin to address some of the immediately pressing functions. The immediate priorities for functions include advocacy, resource mobilization and the promotion of the sharing of countries' experiences, virtually and otherwise. In complement, a United Nations task force on non-communicable diseases, reporting to the Economic and Social Council, could support United Nations country team implementation, including of the recommended actions set out in the joint WHO/UNDP letter on integrating non-communicable diseases into United Nations Development Assistance Framework processes and implementation. In this regard, the experience of the Ad Hoc Inter-Agency Task Force on Tobacco Control could be examined as an existing platform to address one of the major risk factors for non-communicable diseases.**

80. **In the near term, functions could look to: expand partnerships for promoting product access, by focusing on strengthening supply chains and delivery systems and developing market-shaping opportunities; develop an accountability mechanism; promote the prevention and control of non-communicable diseases within universal coverage and primary health-care agendas; and promote advocacy for such diseases in the post-Millennium Development Goals agenda. In the future, functions could further expand to address product development and innovation. Regional organizations should look for opportunities to support national and global action.**

The commercial complexities around the drivers of non-communicable diseases call for increasingly sophisticated tools to manage governance

81. **National and global partnerships need to create opportunities for diverse stakeholders to engage while protecting the integrity of processes from conflicts of interest. Member States and technical agencies should develop examples of good practice and guidelines to facilitate partnerships, recognizing that non-communicable diseases are more determined by public and private commercial interests than most other health challenges.**

Resource mobilization and financing are critical

82. **There is an immediate need to develop guidance materials for domestic budgetary mobilization and allocation to non-communicable diseases, ideally linked to the strengthening of primary health-care systems and the provision of universal coverage. A response is needed for countries' requests for technical support to adopt or expand tobacco and other taxes or surcharges and to apply some or all of the revenues to health care, as appropriate.**

83. **There is also a need for resources to promote wider action at the global level in response to the largely unanswered challenge of non-communicable disease prevention, treatment and care in countries.**

2014 offers a key opportunity to review progress, gaps and accountabilities

84. **The General Assembly requested an update, to be submitted at its sixty-eighth session, in preparation for a comprehensive review and assessment in 2014 of the progress achieved in the prevention and control of non-communicable diseases, drawing on feedback from WHO and other specialized agencies of the United Nations system. The expanding nature of the global response to non-communicable diseases — in terms of both the number of actors involved and the complexity of activities — will mean that any model initiated will likely need further iteration, revision or expansion thereafter. Additionally, given that country-led action underpinned by regulatory, legislative and health-system reform is the key to achieving the agreed 25 by 25 voluntary global target, any partnership formed should scale down as countries eventually fulfil their responsibilities.**